

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4132

## CERTIFICATE OF DEATH

04122

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 Days</u>		TOWN <u>White Haven</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Catherine</u>				<u>Adkins</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 11 1955</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Feb. 23, 1955</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elmer Adkins</u>				14. MOTHER'S MAIDEN NAME <u>Thirby Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs. Thirby Adkins, White Haven Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
492X IMMEDIATE CAUSE (A) <u>Pneumonitis, bilateral</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Hypertension (108) Dehydration Mongolism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 Apr 55</u> to <u>11 April 55</u> , that I last saw the deceased alive on <u>11 Apr 55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Seudeckor Jr.</u>		M.D. <u>976 A. Devotion St Salisbury</u>		DATE SIGNED <u>4/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bivolar Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bivolar, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Conradus H. P. ...</u>		ADDRESS	
DATE <u>4/18/55</u>							

2025429317

# CERTIFICATE OF DEATH

Part 1 of 1

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF DEATH: [Faint text]

5. PLACE OF DEATH: [Faint text]

6. IN MEDICAL CERTIFICATE: [Faint text]

BUREAU V. S.

APR 18 1955

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04123

4133

## CERTIFICATE OF DEATH

Dr. Gilmore

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82 Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>East Church St.</b>		/	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>LILLIE</b> (Middle) <b>RUARK</b> (Last) <b>BAILEY</b>				(Month) <b>APRIL</b> (Day) <b>18</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 3, 1877</b>	9. AGE last birthday <b>77</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At own home</b>		11. BIRTHPLACE (State or foreign country) <b>Siloes, Maryland Wico. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Goslee</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Leatherbury</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Frank T. Bailey (Husband) Hebron, Md.</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <b>Coronary Artery Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Atherosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4/14/55</b> 19, to <b>4/18/55</b> 19, that I last saw the deceased alive on <b>Apr. 18</b> 19 <b>55</b> , and that death occurred at <b>5:35 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>David L. Gilmore</b>		M.D.		ADDRESS (Street, city, town, state) <b>Camden Ave. Salisbury, Maryland</b>		DATE SIGNED <b>Apr. 19 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 20, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hebron, Cemetery</b>		LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>	
24. REC'D BY REGISTRAR DATE <b>4/21/55</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

APR 21 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury  
 OR TOWN Salisbury LENGTH OF STAY (in this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

Peninsula General Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Worcester  
 CITY (If outside corporate limits, write RURAL and give nearest town) Snow Hill  
 OR TOWN 23X-2

STREET ADDRESS (If rural give location)

R.R. #1

3. NAME OF  
 DECEASED:  
 (Type or Print)

(First) Robert

(Middle) C.

(Last) Baine

4. DATE (Month) (Day) (Year)  
 OF DEATH: April 10, 1955

5. SEX:

male

6. COLOR OR RACE:

col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

Nov. 12, 1885

9. AGE last birthday

69 yrs.

IF UNDER 1 YEAR

Months 4 Days 28

IF UNDER 24 HRS.

Hours  Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY:

Own Farm

11. BIRTHPLACE (State or foreign country):

Stockton, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Noah Baine

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Mr. Gulton Baine, Snow Hill, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X IMMEDIATE CAUSE (A) Pneumonia

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

a few days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Asthma. Arterio-sclerotic disease.

20. AUTOPSY? YES ☒ NO ☐

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10/55, 1955, to 4/10/55, that I last saw the deceased

alive on 4/10/55, 1955, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS Professional Md. Salisbury DATE SIGNED 4/12/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

4-12-55

NAME OF CEMETERY OR CREMATORY

Cold Springs Cemetery

LOCATION (City, town, or county)

Giddletown, Md.

DATE REC'D BY LOCAL REGISTRAR

4-12-55

REGISTRAR'S SIGNATURE

Mary W. Holloway

24. FUNERAL DIRECTOR

Clay E. Dennis

ADDRESS

Snow Hill, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1955

BUREAU V. S.



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4135

## CERTIFICATE OF DEATH

04125

33✓

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Salisbury, Maryland</u>		LENGTH OF STAY (in this place) <u>3 yr. 7 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>		<u>3 Vol. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS <u>--</u>		(If rural give location)		✓	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Joseph</u> <u>--</u> <u>Barnes</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 24</u> <u>19</u> <u>55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 6, 1862</u>	<b>9. AGE last birthday</b> <u>92</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Barnes</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Smith</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>450.1 IMMEDIATE CAUSE</b> (A) <u>Toxemia</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Gangrene of right foot</u>						<u>4 months</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Peripheral Arteriosclerosis</u>						<u>Unk.</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>2D. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Sept. 10, 19 51</u> , to <u>April 24, 19 55</u> , that I last saw the deceased alive on <u>April 24, 19 55</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. J. J. J. J. J.</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Maryland</u>		<b>DATE SIGNED</b> <u>4/24/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Cremated</u>		<b>DATE THEREOF</b> <u>4-27-1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>H. M. of Md.</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>4/29/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul Muller, Jr. H. P. Jones</u>			
<b>DATE</b> <u>4/29/55</u>							

The Anatomy Board of Maryland - Christi.

# CERTIFICATE OF DEATH

Part One

1. FULL NAME OF DECEASED

MARIED

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. COUNTY

11. CITY

12. STATE

13. ZIP CODE

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESS

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWN CLERK

24. SIGNATURE OF VOTING CLERK

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF CORONER

29. SIGNATURE OF DISTRICT ATTORNEY

30. SIGNATURE OF COUNTY CLERK

31. SIGNATURE OF TOWN CLERK

32. SIGNATURE OF VOTING CLERK

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF CORONER

37. SIGNATURE OF DISTRICT ATTORNEY

38. SIGNATURE OF COUNTY CLERK

39. SIGNATURE OF TOWN CLERK

40. SIGNATURE OF VOTING CLERK

BUREAU V. 3

APR 29 1955

RECEIVED

4-29-55

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4136

## CERTIFICATE OF DEATH

04126

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Snow Hill</u>		<u>23 X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>R.D.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Barbara Baby Girl Beckett</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4/18/55</u>	9. AGE last birthday <u>12</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Snow Hill Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Lewis Beckett</u>				14. MOTHER'S MAIDEN NAME <u>Almeda Timmons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Lewis Beckett</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
762.5 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>4/18</u> , 19 <u>55</u> , <b>to</b> <u>4/19</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>4/19</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>William C. Morgan</u> <b>ADDRESS</b> (Street, city, town, state) <u>Salisbury Md</u> <b>DATE SIGNED</b> <u>4/19/55</u> <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>H-20-54 Peninsula General Hospital, Salisbury, Md</u> <b>NAME OF CEMETERY OR CREMATORY</b> <u>Peninsula General Hospital</u> <b>LOCATION (City, town, or county)</b> <u>Salisbury, Md</u> <b>(State)</b> <u>Md</u> <b>24. REC'D BY REGISTRAR</b> <u>Mary W. Holloway</u> <b>REGISTRAR'S SIGNATURE</b> <u>Peninsula General Hospital</u> <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Peninsula General Hospital</u> <b>ADDRESS</b> <u>Peninsula General Hospital</u> <u>4045214321</u>							

# CERTIFICATE OF DEATH

FILE NO.

2. USUAL RESIDENCE (HOUSE OR BOARDING)

MARYLAND

1. PLACE OF DEATH

DATE OF DEATH

NAME OF DECEASED

III. MEDICAL CERTIFICATION

1. I hereby certify that the deceased died on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at the age of \_\_\_\_\_ years, \_\_\_\_\_ months, and \_\_\_\_\_ days, of \_\_\_\_\_ (state cause of death) \_\_\_\_\_ (state immediate cause of death) \_\_\_\_\_ (state remote cause of death).

BUREAU Y. B.

APR 22 1955

RECEIVED

4-20-55 Maryland State Department of Health  
4-20-55 Baltimore General Hospital

See birth cert. item 8

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONSBURG</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Route #1</u>		1	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First)		(Middle)		(Last)			
<u>BELL.</u>							
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>MALE</u>		<u>COLOR</u>				<u>April 16, 1955</u>	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
yrs.		Months		Days		Hours Min.	
						<u>1 30</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
				<u>Md.</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>JAMES BELL.</u>				<u>TORITHA JOHNSON.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
						<u>Mother</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>776X IMMEDIATE CAUSE (A)</b>				<u>PREMATURE (1lb 7 1/4 oz)</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Asfour Christensen M.D.</u>				<u>MD</u>		<u>7/23/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>April 19-55</u>		<u>April 19-55</u>		<u>Peninsula General Hospital Salisbury, Wicomico Md.</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DATE April 14-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2045 255 220

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 12 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4137

## CERTIFICATE OF DEATH

04127

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Md.</u>		STREET ADDRESS (If rural give location) <u>RFD #2 Gypsy Hill Road</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Webster Benjamin</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>4 1 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 11, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lincoln Park, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Benjamin</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Hanson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>040-01-3149</u>		17. INFORMANT & ADDRESS <u>Cornelia Patterson, Cambridge, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/31/55</u> , 19 <u>55</u> , to <u>4/1/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/1/55</u> , 19 <u>55</u> , and that death occurred at <u>1:50a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>4/2/55 (4/5/55)</u>		NAME OF CEMETERY OR CREMATORY <u>Reformed Church cemetery</u>		LOCATION (City, town, or county) (State) <u>Pompton Plains N.J.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal (Burial)</u>		24. REC'D BY REGISTRAR <u>4-6-54</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary W. Holloman</u>		ADDRESS <u>Le Compte Funeral Service Cambridge</u>	



22



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04128

4138

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		Since <u>4/18/55</u>		OR TOWN <u>Tyaskin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Pine Bluff State Hospital <u>Salisbury, Md.</u>		STREET ADDRESS (If rural give location)		/	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
Type or Print <u>Ila Jarrett Benton</u>				4 27 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	June 25, 1879	75 yrs.	Months 10	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework				Deals Island, Md.		USA	
13. FATHER'S NAME <u>Calvin JAWES</u>				14. MOTHER'S MAIDEN NAME <u>Emily GIBSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		Lost		Patient on admission to Hospital			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						5 mo	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/18/55</u> , 19....., to <u>4/27/55</u> , 19....., that I last saw the deceased alive on <u>4/27/55</u> , 19....., and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>4/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-30-55</u>		<u>St. Pauls M. E.</u>		<u>Wenona Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5/4/55</u>		<u>Mary Th. Hallaway</u>		<u>L. Webster</u>		<u>Deals Island</u>	



4139

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 96</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BLAKE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 30 1955</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>new born</u>	8. DATE OF BIRTH: <u>April 30, 1955</u>	9. AGE last birthday: <u>2</u> yrs. <u>15</u> Months <u>2</u> Days <u>15</u> Hours <u>15</u> Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Clarence Blake</u>				14. MOTHER'S MAIDEN NAME: <u>Mabel Dous Marshall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mabel Blake, Stockton, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Prematurity</u>		
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 30, 1955, to April 30, 1955, that I last saw the deceased alive on April 30, 1955, and that death occurred at 2:20 A.M., from the causes and on the date stated above.

SIGNATURE Thomas A. Lambdri ADDRESS Salisbury Md. DATE SIGNED 4-30-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>5-2-55</u>	<u>Peninsula General Hospital</u>	<u>Salisbury, Wicomico, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-3-55</u>	<u>Mary W. Holloray</u>	<u>Peninsula General Hospital</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 6 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04130

4140

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		3 weeks		TOWN <u>Berlin</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
91 <u>Deer's Head State Hospital</u>				<u>RFD #3</u> ✓			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John Edward Brittingham</u>				<u>April 8 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Wid.</u>	<u>Mar. 7, 1865</u>	<u>90</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farm</u>		<u>Berlin, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ephram Brittingham</u>				<u>Nellie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>				<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
332X IMMEDIATE CAUSE (A) <u>Recurrent cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 16., 1955.</u> to <u>April 8., 1955.</u> that I last saw the deceased alive on <u>April 8., 1955.</u> and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Guerman</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>8/8/54</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4/10/55</u>		<u>EVERGREEN</u>		<u>BERLIN MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4/11/55</u>		<u>Mary W. Holloway</u>		<u>James B. Burchette</u>		<u>Berlin MD</u>	

**BUREAU V. S.**

APR 12 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04131

4172

## CERTIFICATE OF DEATH

Dr. Lawry, Lee.

Reg. Dist. No. 337

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY OR TOWN <u>Salisbury</u> (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 1 Union</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY OR TOWN <u>Salisbury</u> (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS <u>R.D. # 1 Union</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>MORRIS</u> (First) <u>FRANCIS</u> (Middle) <u>BROWN</u> (Last)				4. DATE OF DEATH <u>April 11</u> <u>th</u> <u>19</u> <u>55</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 24, 1895</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>On Farm</u>		11. BIRTHPLACE (State or foreign country) <u>R.D. # 1 Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. Marion Brown</u>				14. MOTHER'S MAIDEN NAME <u>Florence Pryor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>World War # 1</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Rex Hill (Sister) R.D. # 1 Union</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>4</u> STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>4:15 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> to <u>death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-11-55</u> 19 <u>55</u> , and that death occurred at <u>4:15 P.M.</u> M, from the causes and on the date stated above. SIGNATURE <u>Lee L. Lawry</u> ADDRESS (Street, city, town, state) <u>Fruitland Maryland</u> DATE SIGNED <u>April 11 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.D. # 1 Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>4/14/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

# CERTIFICATE OF DEATH

Age - 100

Place of Birth -

MASSACHUSETTS  
COUNTY OF -

Age -  
Sex -  
Race -  
Religion -

Place of Death -

Time of Death -

Cause of Death -

Immediate Cause -

Underlying Cause -

Contributing Cause -

Mode of Death -

Place of Death -

Time of Death -

Cause of Death -

Immediate Cause -

Underlying Cause -

Contributing Cause -

Mode of Death -

Place of Death -

Time of Death -

Cause of Death -

BUREAU V. S.

APR 14 1955

RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04132

Reg. Dist.

No. 132

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		10 yrs.		12 TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>				STREET ADDRESS (If rural, give location) <u>310 Bowles Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>George Bunting</u>				<u>4 5 19 55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Feb. 11, 1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Accomac, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Albert Bunting</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Roed</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>220-26-2281</u>		17. INFORMANT & ADDRESS: <u>Ida Bunting, 312 Bowles Lane, Salisbury, Md.</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion.</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u> stating underlying cause last (c)		<u>Sudden.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-5-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Household of Ruth</u>		DATE THEREOF <u>April 10, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Accomac, Virginia</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>7-5-55</u>		24. FUNERAL DIRECTOR <u>J. Edgar Thomas, Accomac, Virginia</u>	
REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1955

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9, Film GL80 4-14-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Zwiconico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Princess Anne</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>87 Hampden Ave.</u>			
3. NAME OF DECEASED: (First) <u>Harriett</u> (Middle) <u>Cottman</u> (Last) <u>Cottman</u>				4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>At Home</u>		8. DATE OF BIRTH: <u>Sept 3, 1889</u>	
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Westover, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George Coston</u>				14. MOTHER'S MAIDEN NAME: <u>Myria Ballard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Maggie Cottman, Princess Anne, Md</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>						<u>unknown</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral Thrombosis</u>						<u>11</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>3-12</u> , 19 <u>53</u> , to <u>4-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>55</u> , and that death occurred at <u>5:55</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Willie Q. Ellis, Jr.</u>		M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>4-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>4-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>West Port Office, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-8-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>William H. James</u>		ADDRESS <u>Princess Anne</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



ACCEPTANCE  
EAGLE-AR

COITON CONTENT USA

BUREAU V. S.

APR 11 1955

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. **04134**

No. **332**

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>3 weeks</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Willards</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural, give location) <b>none</b>			
<b>3. NAME OF DECEASED:</b> (First) <b>Emily</b> (Middle) <b>Dennis</b> (Last) <b>Dennis</b>				<b>4. DATE OF DEATH</b> (Month) <b>4</b> (Day) <b>8</b> (Year) <b>19 55</b>			
<b>5. SEX:</b> <b>F</b>		<b>6. COLOR OR RACE:</b> <b>W</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <b>M</b>		<b>8. DATE OF BIRTH:</b> <b>Unknown</b>	
<b>9. AGE last birthday:</b> <b>67</b> yrs.		<b>10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):</b> <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <b>none</b>		<b>11. BIRTHPLACE (State or foreign country):</b> <b>Unknown Oct. 19, 1887</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME:</b> <b>Unknown</b>			
<b>14. MOTHER'S MAIDEN NAME:</b> <b>Unknown</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)</b> <b>Unk.</b>			
<b>16. SOCIAL SECURITY No.:</b>				<b>17. INFORMANT &amp; ADDRESS:</b> <b>Husband- Mr. Edward Dennis</b>			

<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
(a) <b>Immediate cause</b> <b>Acute congestive heart failure</b>						<b>12 hours</b>	
(b) <b>Antecedent cause(s)</b> <b>Third degree burns of 30 % body surface.</b>						<b>26 days</b>	
(c) <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b>							
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDING OF OPERATION:</b>			
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b> <b>Home</b>		<b>21c. (City or town) (County) (State)</b> <b>Willards Wicomico Maryland</b>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <b>3 13 55 5P M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Clothes caught fire while cooking.</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <i>Edward L. Royer</i>		<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>4-9-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>4/11/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Dennis</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Willards Md.</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>7-12-55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary W. Holloway</i>		<b>24. FUNERAL DIRECTOR</b> <i>Peter Whaley Schynell, Jr.</i>		<b>ADDRESS</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 14 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-106A

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4144

## CERTIFICATE OF DEATH

04135

332

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Northoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> <u>100A</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ANNETTE L. ELSEY</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 28, 1951</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Elsey</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Gates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Samuel Elsey, Northoke, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
490X IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>PERICARDITIS</u>				<u>1 day.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>4/9</u> , 19 <u>55</u> , to <u>4/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>55</u> , and that death occurred at <u>4:20</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city, town, state) <u>Northoke Md</u>		DATE SIGNED <u>4/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Northoke Cemetery</u>		LOCATION (City, town, or county) (State) <u>Northoke, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest J. H. Smith, Director, Md.</u>		ADDRESS	
DATE <u>4/20/55</u>							

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX  
4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. PLACE OF BIRTH

15. DATE OF BIRTH

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34. PLACE OF BIRTH

35. DATE OF BIRTH

BUREAU V. B.

APR 20 1955

RECEIVED

15-10000-10000

15-10000-10000

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4145

## CERTIFICATE OF DEATH

04136

327

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 years</u>		TOWN <u>Bozman</u>		<u>20X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS <u>--</u> (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Dona</u>				<u>Faulkner</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>8/11/1875</u>	
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						19 <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Bozman, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Mary Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
		(If Yes, give war or dates of service)					
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Aspiration pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) <u>Arteriosclerotic cardiovascular disease</u>						<u>--</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>with auricular fibrillation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pyleonephritis</u>						<u>--</u>	
19a. DATE OF OPERATION <u>--</u>		19b. MAJOR FINDINGS OF OPERATION <u>--</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>--</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>--</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>2/13</u> , 19 <u>53</u> , to <u>4/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>55</u> , and that death occurred at <u>6:10A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D.		Deer's Head Hospital		DATE SIGNED <u>4/21/55</u>	
		M.D.		Salisbury, Maryland		(State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bozman Private Cemetery</u>		LOCATION (City, town, or county) <u>Bozman, Talbot, Maryland</u>	
24. REC'D BY REGISTRAR <u>4/26/55</u>		REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall, St. Michaels, Md.</u>		ADDRESS	
DATE							

# CERTIFICATE OF DEATH

FILE NO. 10

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BURIAL

6. NAME OF FUNERAL HOME

7. NAME OF MINISTER

8. NAME OF CHURCH

9. NAME OF CEMETERY

10. NAME OF INTERVIEWER

11. NAME OF WITNESS

12. NAME OF SIGNER

13. NAME OF SIGNER

14. NAME OF SIGNER

15. NAME OF SIGNER

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41. NAME OF SIGNER

42. NAME OF SIGNER

43. NAME OF SIGNER

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BURIAL

6. NAME OF FUNERAL HOME

7. NAME OF MINISTER

8. NAME OF CHURCH

9. NAME OF CEMETERY

10. NAME OF INTERVIEWER

11. NAME OF WITNESS

12. NAME OF SIGNER

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43. NAME OF SIGNER

BUREAU V. 11

APR 26 1955

RECEIVED



1

## INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4173

## CERTIFICATE OF DEATH

04137

236

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Delmar</b>		<b>60 yrs</b>		TOWN <b>Delmar</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Maryland Avenue</b>				STREET ADDRESS (If rural give location) <b>Maryland Avenue</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Fannie Elizabeth Fisher</b>				<b>April 29 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>May 9, 1879</b>	<b>75</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Oak Hall, Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Anthony Hall</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Grace Gladding</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mabel Levy, Delmar, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332X IMMEDIATE CAUSE</b> (A) <b>cerebral thrombosis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>	
<b>ANTECEDENT CAUSE(S)</b> (B) <b>arteriosclerosis generalized</b>						<b>20</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Decubitus ulcers lower back and hips</b>						<b>8 months</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>April 28, 1955</b> , <b>to</b> <b>April 29, 1955</b> , <b>that I last saw the deceased alive on</b> <b>April 28, 1955</b> , <b>and that death occurred at</b> <b>4:30 P.M.</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>[Signature]</b>				<b>ADDRESS</b> (Street, city, town, state) <b>303 East Street Delmar, Md.</b>			
<b>DATE THEREOF</b> <b>5-2-55</b>				<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olive</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Delmar, Delaware</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REC'D BY REGISTRAR</b> <b>5/4/55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Harry E. Hudson</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.S. Marvel Co - Delmar, Del</b>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Baltimore		2. COUNTY Baltimore	
3. MARITAL STATUS Married		4. OCCUPATION None	
5. DECEASED'S RESIDENCE 1011 N. E. Street		6. DECEASED'S ADDRESS 1011 N. E. Street	
7. DATE OF DEATH April 23, 1955		8. TIME OF DEATH 10:00 AM	
9. SEX Male		10. RACE White	
11. AGE 65		12. BIRTH DATE May 2, 1890	
13. BIRTH PLACE Maryland		14. BIRTH DATE May 2, 1890	
15. DECEASED'S NAME Anthony Hall		16. DECEASED'S NAME Anthony Hall	
17. DECEASED'S NAME Anthony Hall		18. DECEASED'S NAME Anthony Hall	
19. DECEASED'S NAME Anthony Hall		20. DECEASED'S NAME Anthony Hall	
21. DECEASED'S NAME Anthony Hall		22. DECEASED'S NAME Anthony Hall	
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95. DECEASED'S NAME Anthony Hall		96. DECEASED'S NAME Anthony Hall	
97. DECEASED'S NAME Anthony Hall		98. DECEASED'S NAME Anthony Hall	
99. DECEASED'S NAME Anthony Hall		100. DECEASED'S NAME Anthony Hall	

INVESTIGATION

BUREAU V. S.

MAY 4 1955

RECEIVED

PLEASE WRITE PAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4138  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04138  
 Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u> <u>332</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>home- Anderson Rd.</u>				STREET ADDRESS (If rural, give location) <u>Anderson Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Martha E Goslee</u>				<u>4 29 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>C</u>	<u>S</u>	<u>11-29-38</u>	<u>16</u> yrs.	Months <u>5</u> Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Long</u>				14. MOTHER'S MAIDEN NAME: <u>Thelma Goslee Harmon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Andrew Goslee, Anderson Road, Salisbury, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
057.1 Immediate cause (a) <u>Waterhouse-Friedrichsen Syndrome</u>							
Antecedent cause(s) (b) <u>Septicemia</u>						<u>12 hrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None</u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl H. Royer</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>4-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		24. FUNERAL DIRECTOR <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St. Salisbury, Maryland</u>	

RECEIVED

MAY 5 1955

BUREAU V. S.

William Jones  
Andrew Jones, Anderson Jones, Salisbury, N.C.

11-20-54

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04139

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b> COUNTY <u>Wicomico</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Baltimore City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>WILLIAM</u> <u>JAMES</u> <u>HAASE</u> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>4</u> <u>18</u> <u>19 55</u>			
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Divorced</u> <b>8. DATE OF BIRTH</b> <u>Nov. 18, 1878</u> <b>9. AGE last birthday</b> <u>76</u> yrs.				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cook</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Cook</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Richmond, Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Charles Haase</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Hundley</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>216-05-4716</u> <b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital records</u>			
<b>18. MEDICAL CERTIFICATION</b> <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>450.0</u> IMMEDIATE CAUSE (A) <u>Aspiration pneumonia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Epilepsy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7</u> <u>9 yrs.</u>	
<b>19a. DATE OF OPERATION</b> - -		<b>19b. MAJOR FINDINGS OF OPERATION</b> - -		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/3/</u> , <u>19 51</u> , to <u>4/18</u> , <u>1955</u> , that I last saw the deceased alive on <u>4/18</u> , <u>19 55</u> , and that death occurred at <u>12 midnight</u> .							
<b>SIGNATURE</b> <u>L.V. Maldve, M.D.</u> <b>DATE SIGNED</b> <u>4/19/55</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u>					
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u> <b>DATE THEREOF</b> <u>4-22-55</u> <b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter's</u> <b>LOCATION</b> (City, town, or county) <u>Baltimore</u>		<b>24. REC'D BY REGISTRAR</b> <u>Mary H. Holloway</u> <b>REGISTRAR'S SIGNATURE</b> <u>Fred A. Cole</u> <b>ADDRESS</b> <u>1913 W. Balto St.</u>					
<b>DATE</b> <u>April 22, 1955</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Fred A. Cole</u>					

# CERTIFICATE OF DEATH

FILE NO. 100

1. USUAL RESIDENCE (HOUSE OR CARE)

2. NAME (Last, first, middle)  
 3. SEX  
 4. AGE  
 5. DATE OF BIRTH

6. MARRIAGE

7. OCCUPATION

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE

13. DATE

14. PLACE

15. COUNTY

16. STATE

17. CITY

18. ZIP CODE

19. TELEPHONE

20. HOSPITAL

21. PHYSICIAN

22. NURSE

23. CORONER

24. JUDGE

25. CLERK

26. OTHER

27. SIGNATURE

28. DATE

29. PLACE

30. COUNTY

31. STATE

32. CITY

33. ZIP CODE

34. TELEPHONE

35. HOSPITAL

36. PHYSICIAN

37. NURSE

38. CORONER

39. JUDGE

40. CLERK

41. OTHER

42. SIGNATURE

43. DATE

44. PLACE

45. COUNTY

46. STATE

47. CITY

48. ZIP CODE

49. TELEPHONE

50. HOSPITAL

51. PHYSICIAN

52. NURSE

53. CORONER

54. JUDGE

55. CLERK

56. OTHER

RECEIVED

BUREAU V. 1

APR 25 1965

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4148

## CERTIFICATE OF DEATH

04140

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico Co</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gen Gen Hays</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Wicomico Co</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u> TOWN <u>Salisbury</u> STREET ADDRESS (If rural give location) <u>12</u>			
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Henry</u> (Middle) <u>Henry</u> (Last)				4. DATE OF DEATH <u>4</u> (Month) <u>4</u> (Day) <u>1955</u> (Year)			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 17, 1882</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Henry Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Elizabeth Henry</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 330X IMMEDIATE CAUSE (A) <u>Subarachnoid hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/30/55</u> , 19 <u>55</u> , to <u>4/14/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/4/55</u> , 19 <u>55</u> , and that death occurred at <u>1:10</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. C. Keel Heasler</u>		M.D. <u>113 W. Church St</u>		DATE SIGNED <u>4/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		LOCATION (City, town, or county) <u>Salisbury md</u> (State)			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Doyle W. West</u>		ADDRESS			
DATE <u>4/12/55</u>							



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4174

## CERTIFICATE OF DEATH

04141

332

Dr. Beardsley E.M.

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Rural Salisbury</b>				TOWN <b>Rural Salisbury</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
R.D. # 3 (Ocean City Rd)				R.D. # 3 (Ocean City Road)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>ANNIE</b> (Middle) <b>HOBBS</b> (Last)				(Month) <b>APRIL</b> (Day) <b>13</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Single</b>	<b>Nov. 6, 1879</b>	<b>75</b> yrs.	Months <b>5</b>	Days <b>7</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>House Work</b>		<b>At own Home</b>		<b>R.D. # 3 Salisbury, Md.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Samuel Theo. Hobbs</b>				<b>Eleanora Maddox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>				<b>Miss Lula M. Hobbs (Sister) R.D. # 3</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A)				<b>Carcinoma of stomach</b>		<b>1 yr.</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<b>Anemia</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 19 55</b> , to <b>Apr. 13, 19 55</b> , that I last saw the deceased alive on <b>Apr. 13, 19 55</b> and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Carl M. Beardsley</b>				DATE SIGNED <b>Apr. 15 1955</b>			
ADDRESS (Street, city, town, state)				ADDRESS <b>M.D. East Church St. Salisbury, Maryland</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Apr. 15, 1955</b>		<b>Parsonsburg Cemetery</b>		<b>Parsonsburg, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>4/18/55</b>		<b>Mary W. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

# CERTIFICATE OF DEATH

1955-04-18

1. NAME OF DECEASED

MARYLAND  
JAMES V. GILBERT  
JAMES V. GILBERT

2. PLACE OF DEATH  
JAMES V. GILBERT  
JAMES V. GILBERT

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. MARITAL STATUS

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

44. SIGNATURE OF OTHER

45. SIGNATURE OF OTHER

46. SIGNATURE OF OTHER

47. SIGNATURE OF OTHER

48. SIGNATURE OF OTHER

49. SIGNATURE OF OTHER

50. SIGNATURE OF OTHER

BUREAU V. 2

APR 18 1955

RECEIVED

APR 22

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04142

Reg. Dist. No. 337

4149

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury Md</u>		<u>6 1/2 hr</u>		TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				STREET ADDRESS (If rural give location) <u>R.F.D. Salisbury, Md. (Mt. Hermon)</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Marian</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 20 1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>April 20, 1955</u>		<b>9. AGE last birthday</b> yrs. <u>6</u>	<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>30</u>	<b>IF UNDER 24 HRS.</b> Hours <u>13</u> Min. <u>00</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>P.G. Hospt. Salisbury, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Richard Holloway</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marian Tyler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. Richard Holloway (Father)</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>19. MEDICAL CERTIFICATION</b> <u>R.D.#3 Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>773.5 IMMEDIATE CAUSE (A)</b> <u>Respiratory Failure</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>Prematurity</u>							
<b>(B)</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Apr. 20, 1955</u> , <b>to</b> <u>Apr. 20, 1955</u> , <b>that I last saw the deceased alive on</b> <u>Apr. 20, 1955</u> , <b>and that death occurred at</b> <u>8:20 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William C. Morgan</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury Md.</u> <b>DATE SIGNED</b> <u>4/20/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>April 21, 55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hammond Cemetery.</u>		<b>LOCATION (City, town, or county)</b> <u>Rd. #3 Salisbury, Md.</u> (State)	
<b>24. REC'D BY REGISTRAR</b> <u>4/25/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Holloway &amp; Co. Salisbury, Maryland.</u> <b>ADDRESS</b>			

2045282230



# CERTIFICATE OF DEATH

Reg. No. 100

1. USUAL RESIDENCE (HOUSE OR BUSINESS)  
2. DATE OF DEATH  
3. PLACE OF DEATH  
4. CAUSE OF DEATH  
5. MANNER OF DEATH  
6. SEX  
7. AGE  
8. RACE  
9. COLOR  
10. RELIGION  
11. OCCUPATION  
12. MARITAL STATUS  
13. EDUCATION  
14. SERVICE  
15. SOCIAL SECURITY NUMBER  
16. SIGNATURE OF DECEASED  
17. SIGNATURE OF WITNESS  
18. SIGNATURE OF PHYSICIAN  
19. SIGNATURE OF MINISTER  
20. SIGNATURE OF CLERGYMAN  
21. SIGNATURE OF CHURCH OFFICER  
22. SIGNATURE OF CHURCH MEMBER  
23. SIGNATURE OF CHURCH OFFICER  
24. SIGNATURE OF CHURCH MEMBER  
25. SIGNATURE OF CHURCH OFFICER  
26. SIGNATURE OF CHURCH MEMBER  
27. SIGNATURE OF CHURCH OFFICER  
28. SIGNATURE OF CHURCH MEMBER  
29. SIGNATURE OF CHURCH OFFICER  
30. SIGNATURE OF CHURCH MEMBER

1. USUAL RESIDENCE (HOUSE OR BUSINESS)  
2. DATE OF DEATH  
3. PLACE OF DEATH  
4. CAUSE OF DEATH  
5. MANNER OF DEATH  
6. SEX  
7. AGE  
8. RACE  
9. COLOR  
10. RELIGION  
11. OCCUPATION  
12. MARITAL STATUS  
13. EDUCATION  
14. SERVICE  
15. SOCIAL SECURITY NUMBER  
16. SIGNATURE OF DECEASED  
17. SIGNATURE OF WITNESS  
18. SIGNATURE OF PHYSICIAN  
19. SIGNATURE OF MINISTER  
20. SIGNATURE OF CLERGYMAN  
21. SIGNATURE OF CHURCH OFFICER  
22. SIGNATURE OF CHURCH MEMBER  
23. SIGNATURE OF CHURCH OFFICER  
24. SIGNATURE OF CHURCH MEMBER  
25. SIGNATURE OF CHURCH OFFICER  
26. SIGNATURE OF CHURCH MEMBER  
27. SIGNATURE OF CHURCH OFFICER  
28. SIGNATURE OF CHURCH MEMBER  
29. SIGNATURE OF CHURCH OFFICER  
30. SIGNATURE OF CHURCH MEMBER

BUREAU V. S.

APR 25 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04143

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>		<b>Most of life</b>		TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>526 W. Isabella Street</b>				<b>Lake Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Ethel</b> (Middle) <b>Church</b> (Last) <b>Horsey</b>				(Month) <b>4</b> (Day) <b>20</b> (Year) <b>1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Female</b>	<b>A. A.</b>	<b>Widow</b>	<b>About 1907</b>	<b>About 48 yrs.</b>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Domestic</b>		<b>Private Family</b>		<b>Quantico, Wicomico Co., Md.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>John Church</b>				<b>Ella Bircckhead</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>John Church, 526 W. Isabella St. Salisbury, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <b>Carcinoma of colon</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<b>Indefinite</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>20 Mar. 1955</b> , to <b>20 Apr. 1955</b> , that I last saw the deceased alive on <b>20 Apr. 1955</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>E. A. Furnell</b>		<b>4-24-55</b>		<b>Green Acres Memorial Park</b>		<b>Salisbury, Wicomico Co. Md.</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Burial</b>		<b>Mary H. Holloway</b>		<b>Mary A. Stewart</b>		<b>324 E. Church St. Salisbury, Md.</b>	
24. REC'D BY REGISTRAR		DATE		25. FUNERAL DIRECTOR'S SIGNATURE			
<b>4/25/55</b>							

# CERTIFICATE OF DEATH

1. NAME OF DECEASED J. A. A. A.		2. SEX Male		3. AGE About 45		4. DATE OF BIRTH About 1905		5. PLACE OF BIRTH Maryland		6. OCCUPATION Private Family		7. CAUSE OF DEATH None		8. PLACE OF DEATH John Church, 250 W. Lombard St., Md.	
9. NAME OF DECEASED J. A. A. A.		10. SEX Male		11. AGE About 45		12. DATE OF BIRTH About 1905		13. PLACE OF BIRTH Maryland		14. OCCUPATION Private Family		15. CAUSE OF DEATH None		16. PLACE OF DEATH John Church, 250 W. Lombard St., Md.	

**RECEIVED**  
**BUREAU V. S.**  
APR 25 1955

1-1-155  
Brown Acker Memorial Park, Baltimore, Md.

SHORT-TERM

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## INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4151

## CERTIFICATE OF DEATH

04144

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>5 Days</u>		TOWN <u>Pittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Salisbury</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>BANKS</u> (Middle) <u>HOUCK</u> (Last)				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>8</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 30, 1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George K. Houck</u>				14. MOTHER'S MAIDEN NAME <u>Cora Jackson Houck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4025</u>		17. INFORMANT & ADDRESS <u>Mrs. Olive H. Houck, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
19a. IMMEDIATE CAUSE (A) <u>420.1 Occlusion of Coronary Arteries</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerosis</u>				<u>Yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Dissection of esophagus</u>				<u>Yes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4.8.55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Dissection of esophagus</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4.13</u> , 19 <u>55</u> , to <u>4.8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4.28</u> , 19 <u>55</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H. Brule</u>				ADDRESS (Street, city, town, state) <u>2267 Dunsmuir</u> DATE SIGNED <u>4.11.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>4/13/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Baker</u> ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			

BUREAU V. S.

APR 13 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04145

Dr. <sup>4152</sup>SaundersonReg. Dist. No. <sup>322</sup>

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u> <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. # 3 Mt. Hermon Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>BABY</u> (First) (Middle) (Last) <u>HOWARD</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 7</u> <u>th</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Baby</u>	8. DATE OF BIRTH <u>April 7, 1955</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pen. Gen. Hosp. Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Lyle Howard</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Margaret Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. J. Lyle Howard (Father) R.D. # 3 Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>760.5</u> IMMEDIATE CAUSE (A) <u>Hemorrhage, Cerebral, Intraventricular</u>				<u>Tentorial tear (cerebral)</u>		<u>16 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prematurity (1 lb 14 oz)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 7, 1955</u> to <u>April 7, 1955</u> , that I last saw the deceased alive on <u>April 7, 1955</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Saunderson, M.D.</u>				DATE SIGNED <u>Apr. 9 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>4/12/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway B</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

2045343260



# CERTIFICATE OF DEATH

REG. NO. 100

A. NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

DATE OF DEPARTURE

REASON FOR DEPARTURE

DATE OF RETURN

REASON FOR RETURN

DATE OF DEATH

REASON FOR DEATH

DATE OF BURIAL

REASON FOR BURIAL

DATE OF CREMATION

REASON FOR CREMATION

DATE OF INTERMENT

REASON FOR INTERMENT

DATE OF EXHUMATION

REASON FOR EXHUMATION

DATE OF REINTERMENT

REASON FOR REINTERMENT

BUREAU V. 31

APR 12 1955

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04146

332

Dr. Beardsley

4153

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #4</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lillian</u> (Middle) <u>JONES</u> (Last) <u>JONES</u>				(Month) <u>April</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 17, 1982</u>	<u>72</u> yrs.	Months <u>4</u>	Days <u>7</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work</u>		<u>At Home</u>		<u>Yorkshire England</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Fawcett</u>				<u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mr. George P. Matthews R.D.# 4 Salisbury Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
199.9 IMMEDIATE CAUSE (A) <u>Carcinoma, with widespread metastases</u>						<u>Amos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Longestive heart failure</u>		<u>1 week</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1955</u> , to <u>Apr 24, 1955</u> , that I last saw the deceased alive on <u>Apr 13, 1955</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul M. Beardsley</u>				ADDRESS (Street, city, town, state) <u>909 E. Church St. Salisbury</u>		DATE SIGNED <u>4-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 27, 1955</u>		<u>Parsonsburg, Cemetery</u>		<u>Parsonsburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4/26/55</u>		<u>Mary T. Holloway</u>		<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	

# CERTIFICATE OF DEATH

See Div. 14

A. DEATH RECORD (HOUSE OF DEATH)

NAME OF DECEASED

DATE OF DEATH

B. PLACE OF DEATH

PLACE OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. S.

APR 26 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4175

## CERTIFICATE OF DEATH

04147

Dr. Beardsley

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>X</u> <u>Hebron Rural</u>		LENGTH OF STAY (in this place)		TOWN <u>Hebron Rural</u> <u>X</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 1</u>		STREET ADDRESS <u>R.D. # 1</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES</u> (First) <u>EDWARD</u> (Middle) <u>JONES</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>APR.</u> (Day) <u>21</u> (Year) <u>19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>April 14, 1873</u>	<b>9. AGE last birthday</b> <u>82</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>7</u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Near Allen, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas Jones</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Cannon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Pearl Harrington 206 Marshall St Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>422.2</u> <u>acute pulmonary edema</u>						<u>1 day</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>degenerative heart disease</u>						<u>1 yr.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>4-19</u> <u>19 55</u>		<b>21a. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>4-21</u> <u>19 55</u> , <b>to</b> <u>4-21</u> <u>19 55</u> , <b>that I last saw the deceased alive on</b> <u>4-21</u> <u>19 55</u> , <b>and that death occurred</b> <u>8:50 A.M.</u> <b>from the causes and on the date stated above.</b>				<b>SIGNATURE</b> <u>Dr. Beardsley</u> <b>ADDRESS</b> (Street, city, town, state) <u>M.D. East Church St. Salisbury, Maryland</u> <b>DATE SIGNED</b> <u>Apr. 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Apr. 24 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parsons Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Salisbury, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>4/25/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary St. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>		<b>ADDRESS</b> <u>SALISBURY MARYLAND</u>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

INDUSTRY

MARRIED

PREVIOUS

RESIDENCE

DATE OF

DEATH

CAUSE OF

DEATH

DATE OF

DEATH

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ENCLOSURE

ORIGINAL OF

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND. IT IS TO BE RETURNED TO THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH.

BUREAU V. S.

APR 25 1955

RECEIVED

4154

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

(Regl Dist)

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>768 S. Division St</u>				STREET ADDRESS (If rural, give location) <u>768 S. Division St.</u>			
3. NAME OF DECEASED: (First) <u>WILMER</u> (Middle) <u>CHESTER</u> (Last) <u>JONES</u>		4. DATE OF DEATH <u>APR. 8 th 19 55</u>		5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 15, 1878</u>		9. AGE last birthday: <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, Retired & retired): <u>Foreman at W. F. Allen Co. (Fruit)</u>	
11. BIRTHPLACE (State or foreign country): <u>Powellville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Eli Chester Purnell Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Clarissa Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Minnie M. Jones (Wife) 768 S. Division St</u>			

18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u>				INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause (a) <u>Crowning Aneurism</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Carl H. Kruger</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>Apr. 8 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Apr. 11 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Wicomico Memorial Park</u>	
LOCATION (City, town, or county) (State): <u>Salisbury, Maryland</u>		24. FUNERAL DIRECTOR: <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS: <u>SALISBURY, MARYLAND</u>	
DATE REC'D BY LOCAL REG: <u>4-9-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>			

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

APR 13 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4155

## CERTIFICATE OF DEATH

04149

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>406 Houston Terrace</u>		STREET ADDRESS (if rural give location) <u>406 Houston Terrace</u>					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ALLEN MARTELL (DICK) KELLY</u>				<u>April 10th 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 24, 1903</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant Bar</u>		11. BIRTHPLACE (State or foreign country) <u>Bloxom Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard W. Kelly Jr</u>				14. MOTHER'S MAIDEN NAME <u>Annie W. Dickinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mary Margaret Kelly (Wife) 406 Houston Terrace Salisbury, Maryland</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Swollen</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>4/7</u> , 19 <u>55</u> , to <u>4/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>55</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederic P. Gracie</u>				ADDRESS (Street, city, town, state) <u>M.D. S. Division St Salisbury, Maryland Apr. 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
DATE <u>4/12/55</u>						Walter R. Holloway	

# CERTIFICATE OF DEATH

415

When Death Occurs

LEGAL ATTENTION REQUIRED OF FURNISHER

ALL INFORMATION REQUIRED

MARYLAND

COUNTY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. 8

APR 12 1955

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RECEIVED

4176

04150  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural Salisbury</u>				TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>612 Light St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>Talbot</u> <u>Lewis</u> <u>Larmore</u>		<u>April</u> <u>27</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Dec. 21, 1904</u>	<u>50</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Salesman</u>		<u>Appliance Store</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William W. Larmore</u>				<u>Anna T. Parks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>721-18-0646</u>		<u>Mrs. Lillian G. Larmore, Salisbury, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>973.3</u>					
(a) <u>Asphyxiation-carbon-monoxide poisoning.</u>					
Immediate cause DUE TO					
Antecedent cause(s)					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last					
(b) DUE TO					
(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY?					
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED			
<u>Paul L. Ryan</u>		<u>4-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>5-1-55</u>		<u>Wicomico Memorial Park</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
<u>Salisbury, Md.</u>		<u>Thomson F. Waller</u>		<u>Salisbury, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
<u>4-29-55</u>		<u>Mary W. Holloway</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 2 1955

RECEIVED

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4156

CERTIFICATE OF DEATH

04151

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>		14 years		12 TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 At home - 116 Catherine St.				116 Catherine Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<b>William Fulton Logan</b>				<b>4 - 29 19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>A.A.</b>	<b>Widowed</b>	<b>About 1880</b>	<b>75 yrs.</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Mill Hand</b>		<b>Saw Mill</b>		<b>Horntown, Virginia</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Lemuel Logan</b>				<b>Irene Logan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>No</b>				<b>217-10-3599</b>		<b>Ida Pinkett, 116 Catherine St. Salisbury Md.</b>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
446X IMMEDIATE CAUSE (A) <b>Uremia</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>chronic nephritis arteriosclerosis</b>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 49, to 4-29, 19 55, that I last saw the deceased alive on 4-22, 19 55, and that death occurred at 6:34 A.M. from the causes and on the date stated above.							
SIGNATURE <b>Mary H. Holloway</b>				ADDRESS (Street, city, town, state) <b>Salisbury Md</b>		DATE SIGNED <b>5-2-55</b>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5-3-55</b>		<b>Green Acres Memorial Park</b>		<b>Salisbury, Wicomico Co., Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <b>May 5, 1955</b>		<b>Mary H. Holloway</b>		<b>Mary A. Stewart</b>			
				ADDRESS <b>324 E. Church St Salisbury Maryland</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

RESIDENCE OF DECEASED

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

RESIDENCE OF DECEASED

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

MAY 5 1955

RECEIVED

GREEN ARCADE HOSPITAL, BALTIMORE, MARYLAND

DATE OF DEATH

PLACE OF DEATH



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4157 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04152			
Item 2, Film G181, 5/12/55 <i>1cy</i>			
CERTIFICATE OF DEATH			
Reg. Dist. No. <i>332</i>			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<i>12</i> TOWN <i>Salisbury</i>		<i>Salisbury - 200 E. Church St.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<i>82</i> <i>Peninsula General Hospital</i>		<i>Wilmer Nursing Home</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>SARA</i>		<i>April 30 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>		<i>Dec. 22, 1894</i>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY:	
<i>80</i> yrs.		<i>USA</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>none</i>		<i>none</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Alfred Rord</i>		<i>Emma (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS:			
<i>Mrs. Ralph Bounds, Allen, Md.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>422.1 Pulmonary Embolism</i>			<i>4-6 hrs</i>
ANTECEDENT CAUSE (B) <i>Arteriosclerotic C-V-D.</i>			<i>yes</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <i>Arterial Hypertensive cause.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>None</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-30</i> , 19 <i>55</i> , to <i>4-30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4-30</i> , 19 <i>55</i> , and that death occurred at <i>10:30</i> AM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>William B. Long</i>		<i>Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<i>5-3-55</i>		<i>Allen Cemetery Allen Md.</i>	
NAME OF CEMETERY OR CREMATORY		ADDRESS	
<i>Allen Cemetery</i>		<i>Allen Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR	
<i>5-2-55</i>		<i>Section R. Wilson Primas Anne Md.</i>	
REGISTRAR'S SIGNATURE			
<i>Mary W. Holloray</i>			

RECEIVED

MAY 5 1955

BUREAU V. S.

4158

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Accomac</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chincoteague</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp. Tr.</u>				STREET ADDRESS (If rural give location) <u>Beebe Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>JAMES LUNN</u>				<u>APR 1 20 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>Jan. 27, 1878</u>	
						9. AGE last birthday: <u>77</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self</u>		11. BIRTHPLACE (State or foreign country): <u>Chincoteague, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John P. Lunn</u>				14. MOTHER'S MAIDEN NAME: <u>Rachael McGee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Minnie E. Lunn, Chincoteague, Va.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia, Rt. Lung</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Congestive Heart Failure, Chronic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatoid Arthritis, Chronic</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/20</u> 19 <u>55</u> , to <u>4/20</u> 19 <u>55</u> , that I last saw the deceased alive on <u>4/20</u> 19 <u>55</u> , and that death occurred at <u>322</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Rufus A. Gardner, Jr.</u>				ADDRESS <u>321 S Division St., Salisbury, Md</u>		DATE SIGNED <u>4/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-24-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Thornton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chincoteague, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		24. FUNERAL DIRECTOR <u>William B. Salzer, Chincoteague, Va.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 2 1955

BUREAU V. S.

4159

04154

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>Salisbury</u>		6 Hours		Pocomoke 23-42-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 Peninsula General Hospital				907 Walnut Street			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Day) (Year)	
Christine		LYNN		MANN		April 15 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
Female		White		Single		April 7, 1955	
9. AGE last birthday				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			
- yrs.				None			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Robert P. Mann				Joan Risch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
Robert P. Mann, Pocomoke, Md				I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
				INTERVAL BETWEEN ONSET AND DEATH			
754.4 IMMEDIATE CAUSE				8 days			
ANTECEDENT CAUSE (S)				(A) Cardiac Decompensation + dilation			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
				(B) Congenital Heart disease, aortic			
				DUE TO			
				X Hypo with bicuspid heart +			
				(C) Aortic stenosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 11, 1955, to April 15, 1955 that I last saw the deceased alive on April 15, 1955, and that death occurred at 10:55 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Robert W. Samuelson Jr.				M.D. 4764 Division 5 Building		4/16/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				4-18-55		Cedar Hill	
LOCATION (City, town, or county) (State)				24. FUNERAL DIRECTOR ADDRESS			
Washington, D.C.				Dennis + Watson, Pocomoke, Md.			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
4-16-55				Mary W. Holloman			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 20 1955

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4160 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 04155  
No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Salisbury Md

LENGTH OF STAY (In this place)

minutes

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Peninsula General Hosp.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Worcester

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Stockton238-2

STREET ADDRESS

(If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

WillardMarshall Jr.

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

421955

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MCSJan 4, 1954

yrs.

Months

Days

Hours

Min.

1628282828

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY:

## 13. FATHER'S NAME:

Willard Marshall

## 14. MOTHER'S MAIDEN NAME:

Elizabeth Cropper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Elizabeth Cropper Marshall

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

daysmonths.21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Edgar Wharton

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

4-4-55

M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

4-5-55St. Marks CemeteryStockton, Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-4-55Mary W. AtkinsonEdgar Wharton, New Church, Va

BUREAU V. S.

APR 6 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04156

Dr. Insley- 4161

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>		STREET ADDRESS <u>317 Barclay St</u>				(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CORNELIA (NEALIE) ANN MOORE</u>				<u>Apr. 21 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 26, 1883</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>3</u>	Days <u>25</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Siloes Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Phippin</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Humphreys</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mr. Elijah Moore (Husband) 317 Barclay Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
155X IMMEDIATE CAUSE (A) <u>Carcinoma gall bladder</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Hemorrhage</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 5, 19 55</u> , to <u>April 21, 19 55</u> , that I last saw the deceased alive on <u>April 21, 19 55</u> , and that death occurred at <u>8:50P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Theresa Insley</u>				DATE SIGNED <u>Apr 22, 1955</u>			
M.D. <u>East Main St. Salisbury, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>4/25/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: \_\_\_\_\_

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. CAUSE OF DEATH: \_\_\_\_\_

8. DATE OF DEATH: \_\_\_\_\_

9. PLACE OF DEATH: \_\_\_\_\_

10. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

11. SIGNATURE OF REGISTRAR: \_\_\_\_\_

12. SIGNATURE OF WITNESS: \_\_\_\_\_

13. SIGNATURE OF DECEASED: \_\_\_\_\_

14. SIGNATURE OF NEXT OF KIN: \_\_\_\_\_

15. SIGNATURE OF CLERGYMAN: \_\_\_\_\_

16. SIGNATURE OF BURIAL OFFICIAL: \_\_\_\_\_

17. SIGNATURE OF INTERVIEWER: \_\_\_\_\_

18. SIGNATURE OF CORONER: \_\_\_\_\_

19. SIGNATURE OF JURY: \_\_\_\_\_

20. SIGNATURE OF JUDGE: \_\_\_\_\_

21. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

22. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

23. SIGNATURE OF CITY CLERK: \_\_\_\_\_

24. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

25. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

26. SIGNATURE OF POST OFFICE CLERK: \_\_\_\_\_

27. SIGNATURE OF SCHOOL CLERK: \_\_\_\_\_

28. SIGNATURE OF CHURCH CLERK: \_\_\_\_\_

29. SIGNATURE OF OTHER: \_\_\_\_\_

BUREAU V. 5

APR 25 1955

RECEIVED

1

## INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4162

## CERTIFICATE OF DEATH

04157

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 1/2 months</u>		CITY OR TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS <u>Quantico Road</u>		12		1	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Howard Brooks Patrick</u>				<u>April 27 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>	<b>11. IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb. 5, 1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Carpenter</u>		<u>--</u>		<u>Salisbury, Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Alban Patrick</u>				<u>Rosa Byrd</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unk</u>		<u>184-108900</u>		<u>Mrs. Martha H. Patrick - Same Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332X</b> IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
<u>Recent cerebral thrombosis</u>						<u>4 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<u>Arteriosclerosis</u>						<u>?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>CA of Prostrate with metastasis</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan. 5, 19 55, to Apr. 27, 19 55, that I last saw the deceased alive on Apr. 27, 19 55, and that death occurred at 10:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>[Signature]</u>				<u>Salisbury, Maryland</u>		<u>4/28/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>DURIAL</u>		<u>5/1/55</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, MARYLAND</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>DATE 5/2/55</u>		<u>Mary H. Holloway</u>		<u>THE Hill &amp; Johnson Co.</u>			
				<u>George C. Zieff</u>			

# CERTIFICATE OF DEATH

REV. 10-1-54

1. NAME OF DECEASED: [illegible]

2. PLACE OF DEATH: [illegible]

3. SEX: [illegible]

4. AGE: [illegible]

5. OCCUPATION: [illegible]

6. DATE OF BIRTH: [illegible]

7. PLACE OF BIRTH: [illegible]

8. MARITAL STATUS: [illegible]

9. EDUCATION: [illegible]

10. RELIGION: [illegible]

11. PREVIOUS ILLNESS: [illegible]

12. CAUSE OF DEATH: [illegible]

13. MANNER OF DEATH: [illegible]

14. SIGNATURE OF PHYSICIAN: [illegible]

15. SIGNATURE OF REGISTRAR: [illegible]

16. DATE OF DEATH: [illegible]

17. TIME OF DEATH: [illegible]

18. PLACE OF INTERMENT: [illegible]

19. NAME OF CEMETERY: [illegible]

20. NAME OF FUNERAL HOME: [illegible]

21. NAME OF MINISTER: [illegible]

22. NAME OF CHURCH: [illegible]

23. NAME OF PRIEST: [illegible]

24. NAME OF RABBI: [illegible]

25. NAME OF MINISTER: [illegible]

26. NAME OF CHURCH: [illegible]

27. NAME OF PRIEST: [illegible]

28. NAME OF RABBI: [illegible]

29. NAME OF MINISTER: [illegible]

30. NAME OF CHURCH: [illegible]

31. NAME OF PRIEST: [illegible]

32. NAME OF RABBI: [illegible]

33. NAME OF MINISTER: [illegible]

34. NAME OF CHURCH: [illegible]

35. NAME OF PRIEST: [illegible]

36. NAME OF RABBI: [illegible]

37. NAME OF MINISTER: [illegible]

38. NAME OF CHURCH: [illegible]

39. NAME OF PRIEST: [illegible]

40. NAME OF RABBI: [illegible]

41. NAME OF MINISTER: [illegible]

42. NAME OF CHURCH: [illegible]

43. NAME OF PRIEST: [illegible]

44. NAME OF RABBI: [illegible]

45. NAME OF MINISTER: [illegible]

46. NAME OF CHURCH: [illegible]

47. NAME OF PRIEST: [illegible]

48. NAME OF RABBI: [illegible]

49. NAME OF MINISTER: [illegible]

50. NAME OF CHURCH: [illegible]

51. NAME OF PRIEST: [illegible]

52. NAME OF RABBI: [illegible]

53. NAME OF MINISTER: [illegible]

54. NAME OF CHURCH: [illegible]

55. NAME OF PRIEST: [illegible]

56. NAME OF RABBI: [illegible]

57. NAME OF MINISTER: [illegible]

58. NAME OF CHURCH: [illegible]

59. NAME OF PRIEST: [illegible]

60. NAME OF RABBI: [illegible]

61. NAME OF MINISTER: [illegible]

62. NAME OF CHURCH: [illegible]

63. NAME OF PRIEST: [illegible]

64. NAME OF RABBI: [illegible]

65. NAME OF MINISTER: [illegible]

66. NAME OF CHURCH: [illegible]

67. NAME OF PRIEST: [illegible]

68. NAME OF RABBI: [illegible]

69. NAME OF MINISTER: [illegible]

70. NAME OF CHURCH: [illegible]

71. NAME OF PRIEST: [illegible]

72. NAME OF RABBI: [illegible]

73. NAME OF MINISTER: [illegible]

74. NAME OF CHURCH: [illegible]

75. NAME OF PRIEST: [illegible]

76. NAME OF RABBI: [illegible]

77. NAME OF MINISTER: [illegible]

78. NAME OF CHURCH: [illegible]

79. NAME OF PRIEST: [illegible]

80. NAME OF RABBI: [illegible]

81. NAME OF MINISTER: [illegible]

82. NAME OF CHURCH: [illegible]

83. NAME OF PRIEST: [illegible]

84. NAME OF RABBI: [illegible]

85. NAME OF MINISTER: [illegible]

86. NAME OF CHURCH: [illegible]

87. NAME OF PRIEST: [illegible]

88. NAME OF RABBI: [illegible]

89. NAME OF MINISTER: [illegible]

90. NAME OF CHURCH: [illegible]

91. NAME OF PRIEST: [illegible]

92. NAME OF RABBI: [illegible]

93. NAME OF MINISTER: [illegible]

94. NAME OF CHURCH: [illegible]

95. NAME OF PRIEST: [illegible]

96. NAME OF RABBI: [illegible]

97. NAME OF MINISTER: [illegible]

98. NAME OF CHURCH: [illegible]

99. NAME OF PRIEST: [illegible]

100. NAME OF RABBI: [illegible]

BUREAU V. S.

MAY 2 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4163

## CERTIFICATE OF DEATH

04158

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>WICOMICO</b>		STATE <b>MARYLAND</b>		COUNTY <b>PRINCE GEORGE'S</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN SALISBURY</b>		LENGTH OF STAY (In this place) <b>7 weeks</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN RITCHIE</b>		<b>16X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>91 DEER'S HEAD STATE HOSPITAL</b>		STREET ADDRESS <b>DARCY ROAD</b>		(If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>(EMILY) Emma Frances PERSINGER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 13th 1955</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>3/6/1864</b>	<b>9. AGE last birthday</b> <b>91</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mason County, W. Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown James Siders</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown Mary Jane Crowell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital records</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>422.1</b> IMMEDIATE CAUSE (A) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>ARTERIOSCLEROSIS, GENERAL</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> -- --		<b>19b. MAJOR FINDINGS OF OPERATION</b> -- --				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> -- --		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) -- --			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) -- --		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> -- --			
<b>22. I hereby certify that I attended the deceased from 2/28, 1955, to 4/13, 1955, that I last saw the deceased alive on 4/13, 1955, and that death occurred at 12/30 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>L.V. Maldve</i> <b>L.V. Maldve, M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Deer's Head State Hospital, Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>4/13/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>4/15/1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wash. Nat'l Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Suitland, Pr. Geo. Co., Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE April 14 '55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Company, Riverdale, Md.</b>			

# CERTIFICATE OF DEATH

MD. REG. NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE AND PLACE OF DEATH

7. CAUSE OF DEATH

8. SIGNATURE

9. DATE

10. PLACE

11. SIGNATURE

12. NAME OF PHYSICIAN

13. NAME OF HOSPITAL

14. NAME OF NURSE

15. NAME OF MINISTER

16. NAME OF CHURCH

17. NAME OF FUNERAL HOME

18. NAME OF CEMETERY

19. NAME OF BURIAL PLACE

BUREAU V. 8

APR 22 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4177

## CERTIFICATE OF DEATH

04159

Reg. Dist. No. 232

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Quantico</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Quantico</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 1</u>				STREET ADDRESS (if rural give location) <u>R.D. # 1</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>PAULINE</u>		(Middle) <u>AMELIA</u>		(Last) <u>SENKBEIL</u>		(Month) <u>April</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1, 1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>10</u> Days <u>5</u>		Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Bettcher</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Veint</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Gustav M. Senkbeil-R.D.#1 Quantico</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> <u>Maryland (Husband)</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>6 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>						<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
<b>22. I hereby certify that I attended the deceased from <u>15 MARCH 1952</u> to <u>6 APRIL 1955</u>, that I last saw the deceased alive on <u>6 APRIL 1955</u>, and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>Richard H. Saunders</u>				ADDRESS (Street, city, town, state) <u>Nanticoke Md.</u> DATE SIGNED <u>April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>4/12/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

# CERTIFICATE OF DEATH

Reg. Form 100

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. PREVIOUS ILLNESS

14. MEDICAL ATTENDANCE

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF BURIAL OFFICIAL

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF VENDOR

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

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83. SIGNATURE OF OTHER

84. SIGNATURE OF OTHER

85. SIGNATURE OF OTHER

86. SIGNATURE OF OTHER

BUREAU V. 3

APR 12 1955

RECEIVED

1

INSTRUCTIONS

hours after death.

The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4164

## CERTIFICATE OF DEATH

04160

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>1 Day</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
3. NAME OF DECEASED (Type or Print) <b>WALTER LEVIN SMITH</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>4 21 1955</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug, 10, 1884</b>	9. AGE last birthday <b>70</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Robert Smith</b>				14. MOTHER'S MAIDEN NAME <b>Maria Hayman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-26-5592</b>		17. INFORMANT & ADDRESS <b>Mrs. Mattie P. Smith, Same</b>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <b>420.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>4-21-55</b> to <b>4-21-55</b> , that I last saw the deceased alive on <b>4-21-55</b> , and that death occurred at <b>4-21-55</b> from the causes and on the date stated above.							
SIGNATURE <b>W. Bradley</b>		M.D. <b>Salisbury</b>		ADDRESS (Street, city, town, state) <b>Pittsville, Md</b>		DATE SIGNED <b>4-22-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4/23/55</b>		NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
24. REC'D BY REGISTRAR <b>4/25/55</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Md.</b> <b>Herman T. Baker</b>			



# CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL HEALTH DEPARTMENT OR REGISTRY

City

County

State

Sex

Residence

Age

Occupation

Place of Death

Signature

Signature

Signature

Male

White

Married

Age 10, 1981

To

Maryland

Residence

Residence

Residence

Residence

BUREAU V. S.

APR 25 1955

RECEIVED

Residence

Residence

Residence

The Hill & Johnson Co.



**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4165

## CERTIFICATE OF DEATH

04161

332

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		21 days		TOWN <u>Delmar</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
81 <u>Peninsula General Hospital</u>				405 <u>Maryland Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>ERNEST</u> (Middle) <u>EDWARD</u> (Last) <u>Sullivan</u>				April 24 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
Male	White	Married	Aug. 4, 1888	66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Business</u>				<u>Railroad</u>		<u>Whitesville Del</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Sullivan</u>				<u>Ellen Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>716-03-1609</u>		<u>Katie Sullivan Delmar Del</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
332X IMMEDIATE CAUSE (A)				<u>Cerebral Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... 19....., to..... 19....., that I last saw the deceased alive on..... 19....., and that death occurred at..... 8:20 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>William B. Ellis</u> M.D.				<u>Salisbury, Md.</u>		<u>4-24-54</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-27-55</u>		<u>Int olive</u>		<u>Delmar Del</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4/27/55</u>		<u>Mary H. Holloway</u>		<u>W.S. Memorial Co Delmar Del</u>			

# CERTIFICATE OF DEATH

REG. NO. 1-10

1. DECEASED'S NAME (Last, first, middle)

2. SEX ( ) Male ( ) Female

3. AGE ( ) Years ( ) Months ( ) Days

4. DATE OF BIRTH ( ) Year ( ) Month ( ) Day

5. PLACE OF BIRTH ( ) State ( ) Country

6. OCCUPATION

7. CAUSE OF DEATH ( ) Disease ( ) Injury ( ) Poison ( ) Other

8. MANNER OF DEATH ( ) Natural ( ) Accidental ( ) Suicidal ( ) Homicidal ( ) Undetermined

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CORONER

23. SIGNATURE OF JURY

24. SIGNATURE OF COURT

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF COURT

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF REGISTRAR

32. SIGNATURE OF WITNESSES

33. SIGNATURE OF DECEASED

34. SIGNATURE OF NEXT OF KIN

35. SIGNATURE OF CLERK

36. SIGNATURE OF JUDGE

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF CORONER

39. SIGNATURE OF JURY

40. SIGNATURE OF COURT

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CORONER

44. SIGNATURE OF JURY

45. SIGNATURE OF COURT

46. SIGNATURE OF JUDGE

47. SIGNATURE OF SHERIFF

48. SIGNATURE OF CORONER

49. SIGNATURE OF JURY

50. SIGNATURE OF COURT

51. SIGNATURE OF JUDGE

52. SIGNATURE OF SHERIFF

53. SIGNATURE OF CORONER

54. SIGNATURE OF JURY

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56. SIGNATURE OF JUDGE

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72. SIGNATURE OF SHERIFF

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76. SIGNATURE OF JUDGE

77. SIGNATURE OF SHERIFF

78. SIGNATURE OF CORONER

79. SIGNATURE OF JURY

80. SIGNATURE OF COURT

81. SIGNATURE OF JUDGE

82. SIGNATURE OF SHERIFF

83. SIGNATURE OF CORONER

84. SIGNATURE OF JURY

85. SIGNATURE OF COURT

86. SIGNATURE OF JUDGE

87. SIGNATURE OF SHERIFF

88. SIGNATURE OF CORONER

89. SIGNATURE OF JURY

90. SIGNATURE OF COURT

91. SIGNATURE OF JUDGE

92. SIGNATURE OF SHERIFF

93. SIGNATURE OF CORONER

94. SIGNATURE OF JURY

95. SIGNATURE OF COURT

96. SIGNATURE OF JUDGE

97. SIGNATURE OF SHERIFF

98. SIGNATURE OF CORONER

99. SIGNATURE OF JURY

100. SIGNATURE OF COURT

101. SIGNATURE OF JUDGE

102. SIGNATURE OF SHERIFF

103. SIGNATURE OF CORONER

104. SIGNATURE OF JURY

105. SIGNATURE OF COURT

106. SIGNATURE OF JUDGE

107. SIGNATURE OF SHERIFF

108. SIGNATURE OF CORONER

109. SIGNATURE OF JURY

110. SIGNATURE OF COURT

111. SIGNATURE OF JUDGE

112. SIGNATURE OF SHERIFF

113. SIGNATURE OF CORONER

114. SIGNATURE OF JURY

115. SIGNATURE OF COURT

116. SIGNATURE OF JUDGE

117. SIGNATURE OF SHERIFF

118. SIGNATURE OF CORONER

119. SIGNATURE OF JURY

120. SIGNATURE OF COURT

121. SIGNATURE OF JUDGE

122. SIGNATURE OF SHERIFF

123. SIGNATURE OF CORONER

124. SIGNATURE OF JURY

125. SIGNATURE OF COURT

126. SIGNATURE OF JUDGE

127. SIGNATURE OF SHERIFF

128. SIGNATURE OF CORONER

129. SIGNATURE OF JURY

130. SIGNATURE OF COURT

131. SIGNATURE OF JUDGE

132. SIGNATURE OF SHERIFF

133. SIGNATURE OF CORONER

134. SIGNATURE OF JURY

135. SIGNATURE OF COURT

136. SIGNATURE OF JUDGE

137. SIGNATURE OF SHERIFF

138. SIGNATURE OF CORONER

139. SIGNATURE OF JURY

140. SIGNATURE OF COURT

141. SIGNATURE OF JUDGE

142. SIGNATURE OF SHERIFF

143. SIGNATURE OF CORONER

144. SIGNATURE OF JURY

145. SIGNATURE OF COURT

146. SIGNATURE OF JUDGE

147. SIGNATURE OF SHERIFF

148. SIGNATURE OF CORONER

149. SIGNATURE OF JURY

150. SIGNATURE OF COURT

151. SIGNATURE OF JUDGE

152. SIGNATURE OF SHERIFF

153. SIGNATURE OF CORONER

154. SIGNATURE OF JURY

155. SIGNATURE OF COURT

156. SIGNATURE OF JUDGE

157. SIGNATURE OF SHERIFF

158. SIGNATURE OF CORONER

159. SIGNATURE OF JURY

160. SIGNATURE OF COURT

161. SIGNATURE OF JUDGE

162. SIGNATURE OF SHERIFF

163. SIGNATURE OF CORONER

164. SIGNATURE OF JURY

165. SIGNATURE OF COURT

166. SIGNATURE OF JUDGE

167. SIGNATURE OF SHERIFF

168. SIGNATURE OF CORONER

169. SIGNATURE OF JURY

170. SIGNATURE OF COURT

171. SIGNATURE OF JUDGE

172. SIGNATURE OF SHERIFF

173. SIGNATURE OF CORONER

174. SIGNATURE OF JURY

175. SIGNATURE OF COURT

176. SIGNATURE OF JUDGE

177. SIGNATURE OF SHERIFF

178. SIGNATURE OF CORONER

179. SIGNATURE OF JURY

180. SIGNATURE OF COURT

181. SIGNATURE OF JUDGE

182. SIGNATURE OF SHERIFF

183. SIGNATURE OF CORONER

184. SIGNATURE OF JURY

185. SIGNATURE OF COURT

186. SIGNATURE OF JUDGE

187. SIGNATURE OF SHERIFF

188. SIGNATURE OF CORONER

189. SIGNATURE OF JURY

190. SIGNATURE OF COURT

191. SIGNATURE OF JUDGE

192. SIGNATURE OF SHERIFF

193. SIGNATURE OF CORONER

194. SIGNATURE OF JURY

195. SIGNATURE OF COURT

196. SIGNATURE OF JUDGE

197. SIGNATURE OF SHERIFF

198. SIGNATURE OF CORONER

199. SIGNATURE OF JURY

200. SIGNATURE OF COURT

201. SIGNATURE OF JUDGE

202. SIGNATURE OF SHERIFF

203. SIGNATURE OF CORONER

204. SIGNATURE OF JURY

205. SIGNATURE OF COURT

206. SIGNATURE OF JUDGE

207. SIGNATURE OF SHERIFF

208. SIGNATURE OF CORONER

209. SIGNATURE OF JURY

210. SIGNATURE OF COURT

211. SIGNATURE OF JUDGE

212. SIGNATURE OF SHERIFF

213. SIGNATURE OF CORONER

214. SIGNATURE OF JURY

215. SIGNATURE OF COURT

216. SIGNATURE OF JUDGE

217. SIGNATURE OF SHERIFF

218. SIGNATURE OF CORONER

219. SIGNATURE OF JURY

220. SIGNATURE OF COURT

221. SIGNATURE OF JUDGE

222. SIGNATURE OF SHERIFF

223. SIGNATURE OF CORONER

224. SIGNATURE OF JURY

225. SIGNATURE OF COURT

226. SIGNATURE OF JUDGE

227. SIGNATURE OF SHERIFF

228. SIGNATURE OF CORONER

229. SIGNATURE OF JURY

230. SIGNATURE OF COURT

231. SIGNATURE OF JUDGE

232. SIGNATURE OF SHERIFF

233. SIGNATURE OF CORONER

234. SIGNATURE OF JURY

235. SIGNATURE OF COURT

236. SIGNATURE OF JUDGE

237. SIGNATURE OF SHERIFF

238. SIGNATURE OF CORONER

239. SIGNATURE OF JURY

240. SIGNATURE OF COURT

241. SIGNATURE OF JUDGE

242. SIGNATURE OF SHERIFF

243. SIGNATURE OF CORONER

244. SIGNATURE OF JURY

245. SIGNATURE OF COURT

246. SIGNATURE OF JUDGE

247. SIGNATURE OF SHERIFF

248. SIGNATURE OF CORONER

249. SIGNATURE OF JURY

250. SIGNATURE OF COURT

251. SIGNATURE OF JUDGE

252. SIGNATURE OF SHERIFF

253. SIGNATURE OF CORONER

254. SIGNATURE OF JURY

255. SIGNATURE OF COURT

256. SIGNATURE OF JUDGE

257. SIGNATURE OF SHERIFF

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18 Film 181 5-18-55 ams		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		04162
4166		CERTIFICATE OF DEATH		Reg. Dist. No. 332
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 TOWN SALISBURY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Girdletree 238-2</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>✓</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)		
(First) (Middle) (Last)		OF DEATH: <u>APRIL 27 1955</u>		
5. SEX: <u>7</u> 6. COLOR OR RACE: <u>Col.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Oct-23, 1954</u>		9. AGE last birthday <u>6</u> yrs. <u>3</u> Months <u>5</u> Days <u></u> Hours <u></u> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u></u>		10B. KIND OF BUSINESS OR INDUSTRY: <u></u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Wallas H. Taylor</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME: <u>Clara Tindley</u>		17. INFORMANT & ADDRESS: <u>Mrs. Clara Taylor, Girdletree Md.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
391.2 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>				<u>Sudden</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Septicemia</u>				<u>24 hrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Otitis Media &amp; Possible early Bronchopneumonia</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4/26</u> , 1955, to <u>4/27</u> , 1955, that I last saw the deceased alive on <u>4/27</u> , 1955, and that death occurred at <u>7:25</u> P.M. from the causes and on the date stated above.				
SIGNATURE <u>William C. Morgan</u>		ADDRESS <u>Salisbury</u>		DATE SIGNED <u>4/28/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>4-28-55</u> NAME OF CEMETERY OR CREMATORY <u>Cool Springs Cemetery</u>		LOCATION (City, town, or county) (State) <u>Girdletree Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>4-29-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR ADDRESS <u>Clay E. Dennis, Swanton Hill, Md</u>

RECEIVED

MAY 2 1955

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4167

## CERTIFICATE OF DEATH

04163

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		9 days		OCEAN CITY		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				Route # 1 ✓			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>LILLIE</u>		(Middle) <u>MAY</u>		(Last) <u>THORNTON</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Female	White	Widowed	4/2/1872	83 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Unknown Home</u>		Accomac, Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James W. Nelson</u>				<u>Tabitha W. Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		No		<u>Hospital records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						12 hours	
442X IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis, general</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4</u> , 19 <u>55</u> , to <u>April 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr. 13</u> , 19 <u>55</u> , and that death occurred at <u>2:50P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D. Deer's Head State Hospital				DATE SIGNED <u>4/13/55</u>	
M.D. <u>Salisbury, Maryland</u>		ADDRESS (Street, city, town, state)					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APR 16 1955</u>		<u>WHAT COAT</u>		<u>SNOW HILL MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4/21/55</u>		<u>Mary H. Holloway</u>		<u>Anna R. Burby</u>		<u>Berlin Md</u>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

4168

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04164

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (In this place) <b>2 mos.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN East New Market</b>		<b>09X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 142 Second Street</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Anna Covington Townsend</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>4 - 5 - 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>A. A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>7-6-1889</b>	<b>9. AGE last birthday</b> <b>65 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>8 29</b>		<b>IF UNDER 24 HRS.</b> Hours Min. <b>29</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Maid</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Phila.Pa. Prov. Trust Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Snow Hill, Worcester Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert Covington</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy Purnell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>173-22-5672</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Rev. R. S. Townsend, East New Market, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>174X IMMEDIATE CAUSE (A)</b> <b>Carcinoma of uterus</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Undetermined</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 4 March 1955, to 5 April 1955, that I last saw the deceased alive on 5 April 1955, and that death occurred at 12 M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>R. S. Townsend</b>				<b>ADDRESS (Street, city, town, state)</b> <b>652 W main ST, Salisbury, Md.</b>			
<b>DATE SIGNED</b> <b>5 April 55</b>				<b>DATE SIGNED</b> <b>5 April 55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>4-7-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Snow Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Snow Hill, Worcester Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>4/11/55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mary A. Stewart</b>		<b>ADDRESS</b> <b>324 E. Church Street Salisbury, Maryland</b>	

# CERTIFICATE OF DEATH

REG. DIST. NO.

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. PLACE OF BIRTH

8. NAME OF DECEASED

9. NAME OF PHYSICIAN

BUREAU V. S.

APR 11 1935

RECEIVED

10. NAME OF REGISTRAR

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

4169

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PRINCESS ANNE</u> 19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Oliver Vernon Tyler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 11 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 10, 1888</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>David Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hewitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-9142</u>	
17. INFORMANT & ADDRESS <u>Mrs Ada Tyler</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-24</u> , 19 <u>55</u> , to <u>4-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>55</u> , and that death occurred at <u>8:25</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>	
DATE <u>4-12-55</u>		DATE SIGNED <u>4-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 14, 1955</u>	
24. REC'D BY REGISTRAR <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry B. Miles</u>	
25. ADDRESS <u>Upper Fairmount, Md</u>			



4178

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 04166

No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN Eden LENGTH OF STAY (in this place) 3 weeks  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Princess Anne Road RFD # 13

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Florida, COUNTY  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 TOWN Del Ray Beach 48X-3  
 STREET ADDRESS (If rural, give location) unknown

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) Fernando Wester

4. DATE OF DEATH (Month) (Day) (Year)  
4 7 19 55

5. SEX: M F 6. COLOR OR RACE: C 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: 3-24-1903 9. AGE last birthday: 52 yrs. 10. IF UNDER 1 YEAR Months 0 Days 13 Hours 0 Min. 11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer 10b. KIND OF BUSINESS OR INDUSTRY: Farming 11. BIRTHPLACE (State or foreign country): Havana, Florida 12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

Henry Wester

## 14. MOTHER'S MAIDEN NAME:

Lucille Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
Unknown

16. SOCIAL SECURITY No.: 261-10-8580

## 17. INFORMANT &amp; ADDRESS:

Mrs. Ollie Mae Wester, Del Ray Beach, Fla.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
 Immediate cause (a) Coronary occlusion  
 DUE TO

Antecedent cause(s) (b) DUE TO  
 Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

## INTERVAL BETWEEN ONSET AND DEATH

Sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Earl L. Royer

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

4-8-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 4-12-55

NAME OF CEMETERY OR CREMATORY Del Ray Beach Cemetery

LOCATION (City, town, or county) (State) Del Ray Beach, Florida

DATE REC'D BY LOCAL REG 4-9-55

REGISTRAR'S SIGNATURE

Mary W. Holloway

24. FUNERAL DIRECTOR

Mary A. Stewart, Salisbury, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 13 1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4170

CERTIFICATE OF DEATH

Reg. Dist. No. 04167 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Campbelltown</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Campbelltown</u>			
3. NAME OF DECEASED: (First) <u>PATRICIA</u>		(Middle) <u>Anne</u>		(Last) <u>Williams</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 12 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Aug 10, 1940</u>	9. AGE last birthday: <u>14</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Milton Allen Williams</u>				14. MOTHER'S MAIDEN NAME: <u>Kathleen Watson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Milton Allen Williams</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
430.0 IMMEDIATE CAUSE (A) <u>Cerebral embolus</u>		<u>1 day</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Subacute bacterial endocarditis</u>		<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
--	--

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 4/12, 1955, to 4/12, 1955, that I last saw the deceased alive on 4/12, 1955, and that death occurred at 3:47 P.M. from the causes and on the date stated above.

SIGNATURE <u>William R. Ellis, Jr.</u>	ADDRESS <u>Salisbury, Md.</u>	DATE SIGNED <u>4-18-55</u>
--	-------------------------------	----------------------------

23. BURIAL CREMATION, REMOVAL (SPECIFY)	DATE THEREOF <u>4-15-55</u>	NAME OF CEMETERY OR CREMATORY <u>Williams Family Cemetery</u>	LOCATION (City, town, or county) <u>Salisbury, Md.</u>	(State)
---	-----------------------------	---	--	---------

DATE REC'D BY LOCAL REGISTRAR <u>4-13-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Peter Whaley</u>	ADDRESS <u>Salisbury, Del.</u>
--	---	--	--------------------------------

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 4171 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 04168

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Baldwin</u>	LENGTH OF STAY (in this place) <u>3 days</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Ocean City</u>	<u>23X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Ann's General Hospital</u>		STREET ADDRESS <u>171</u>	(If rural, give location) <u>✓</u>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Elson</u>	(Middle) <u>Wilson</u>	(Month) <u>April</u>	(Day) <u>4</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>DR.</u>	8. DATE OF BIRTH: <u>1908</u>
			9. AGE last birthday: <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>DR.</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Don't know</u>
13. FATHER'S NAME: <u>Elson</u>		14. MOTHER'S MARRIED NAME: <u>Merrie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>DR.</u>		16. SOCIAL SECURITY No.: <u>✓</u>	
		17. INFORMANT & ADDRESS: <u>Hospital record</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) DUE TO <u>Homicide by firearm</u> Antecedent cause(s) (b) DUE TO <u>giving rise to the above cause stating underlying cause last</u> (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>George Place W. Ocean City Worcester Md</u>	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>P. E. Antorino</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/6/55</u>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>April 7/55</u>	NAME OF CEMETERY OR CREMATORY <u>Snow Hill</u>
DATE REC'D BY LOCAL REG. <u>4-9-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	MUNERAL DIRECTOR <u>Alley C. Dennis, Snow Hill, Md</u>

BUREAU V. S.

APR 13 1955

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